Prescription Drug Management in Workers' Compensation

The Tenth Annual Survey Summary Report (2012 data)

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Introduction

This is the tenth year that this survey has been conducted. For the first six years this was done by Health Strategy Associates, LLC, a consulting firm owned by Joseph Paduda. Paduda is also the president of CompPharma LLC, a workers' compensation pharmacy advocacy and education firm, and the responsibility for the survey was transferred to CompPharma in 2009.

For 10 years HSA (and now CompPharma) has surveyed executives and senior management at workers' compensation payers about prescription drug management. Historically, the survey was focused on PBM capabilities and program results, cost drivers and cost trends, opinions, perceptions and attitudes about pharmacy management in workers' compensation. Special attention was paid to cost drivers, management approaches, vendors, problems, and solutions.

This year, we continue to use both quantitative and qualitative measures in the survey, with the questionnaire structured in such a way as to "triangulate" on specific issues and confirm opinions and perspectives, thereby providing readers with confidence in the survey's findings. The quantitative questions used a 1-5 rating scale, with 1 on the low end (e.g., worse or less important) and 5 at the high end (best or most important). Note – not all respondents answered all questions, thus response rates/numbers will not always correlate with the total number of payers.

Yvonne Guibert conducted the survey again this year; we are indebted to Yvonne for her diligent and careful work. Finally, we also want to express our thanks to the workers' compensation professionals who carefully and thoughtfully respond to the survey. Their willing participation is deeply appreciated. All responses are confidential, and care has been taken to "sanitize" responses to protect the anonymity of the respondents.

Interviews were conducted in the early summer of 2013, with data on spend and other metrics derived from respondents' 2012 results.

Editorial note – Readers should not confuse "price" with "cost." In this report, "cost" is defined as total drug expenses for a payer. Price is a contributor to cost, as is utilization, or the number and type of drugs dispensed. Think of cost as Cost = Price x Utilization.

Premise

Regardless of the impact of outside influences, such as fee schedules, new drugs on the market, or claim frequency, better programs properly implemented will deliver lower loss costs, which will translate to lower combined ratios and higher profits for work comp insurers/lower work comp costs for self-insureds and better care for injured workers.

Background

Pharmacy management does not occur in a vacuum. Outside factors profoundly affect pharmacy in workers' compensation, factors that include societal issues, e.g., the explosive growth in opioid abuse. Other factors are overall medical trend, practice pattern evolution, the flow of drugs into the system and timing of patent expiration, pharmaceutical marketing practices, federal and state laws and regulations, and the international pharmaceutical industry.

Closer to home, pharmacy is a component of workers' compensation medical expenses, which totaled approximately $30 billion in 2010 (source: National Academy of Social Insurance 2010 WC Report, 8/2012, trended forward using National Council on Compensation Insurance (NCCI) medical inflation rates from NCCI Annual Issues Symposium State Of the Line, 5/2013). After much analysis, we have come to the conclusion that it is currently not possible to precisely calculate workers compensation drug spend. There are several reasons for this:

- Different estimates are based on data from different states, and the various estimates use differing methodologies. The methodology used by NCCI, which produces an approximate cost of $6 billion, is based on an analysis of spend in the last year of the claim, and the data is from NCCI reporting states
- In contrast, anecdotal information from payers indicates drug costs account for 10% to 14% of medical spend, or around $4 billion.
- The basis for determining what products or billing codes are included as drug spend varies among and between payers and jurisdictions.
- Drugs are dispensed in a variety of settings and by a variety of providers; therefore some drug costs may be included in other charge categories. For example, the use of specialty drugs may be billed under home health care/durable medical equipment services, while long-term care and hospital-dispensed medications typically are counted as facility expenses
- Physician-dispensed drugs may or may not be counted towards drug spend, as they can be billed on standard medical billing forms with the cost "rolled-up" under physician costs for reporting purposes.

Respondents

Respondents were decision makers and operations staff in carriers and TPAs with 2012 drug expenses ranging from $1.7 million to $168 million. The 23 respondents' total Rx expenditure amounted to $698 million.

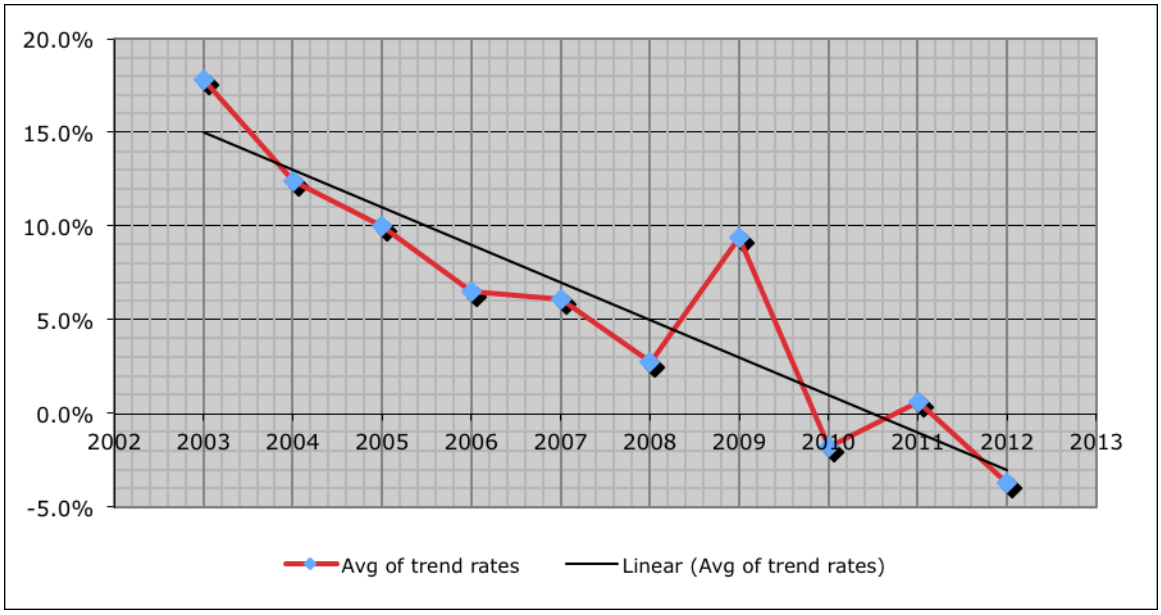
Findings

Inflation/trend in drug costs

For the third consecutive year, respondents' drug costs declined in real terms, both for the average across all respondents (-3.9%) and the average of each respondent (-3.7%). Notably, this occurs after 2009 year's increase of 9.4 points. That jump marked the first increase in the inflation rate in six years.

To validate and better understand this rather surprising result, we looked at each individual respondent's trend rate. Only six of the 23 respondents experienced increases in their drug spend, with most in the low single digits, a slight increase in the number with declines over the previous year. Of the entities experiencing increases, only one saw a significant jump. Increases do not appear to have been primarily driven by provider behavior, rather, increases were the result of:

- Increases in claim volume and severity due to a changing claims environment
- Better information and more complete capture of script data
- Increased new business



Over the last decade, the pharmacy cost inflation rate has dropped by over 21 points. Clearly this bears additional discussion.

PBMs came into their own in the early part of the 2000s, with clinical management programs becoming more effective as the decade went on. Coupled with declines in new branded drugs, a large number of popular drugs going off-patent, and effective generic conversion programs, PBMs and payers have been remarkably successful in not just managing, but actually reducing total pharmacy costs.

The size of the "problem"

Despite relatively flat drug costs, respondents continue to be significantly concerned about the issue. In response to the question "How big a problem are drug costs?" on a scale of 1 through 5 with 3 being "drug costs are equally as important as other medical cost issues," drug costs were rated a 3.9, or "more important than other medical cost issues." This is essentially unchanged from the prior two years. Individual responses to the qualitative questions on the survey also indicated continued concern with drug costs.

Moreover, respondents are concerned (4.0) that drug costs will be more of a problem in the next 12-24 months than they are today.

Cost drivers

There's an obvious dichotomy here; respondents have seen pharmacy costs come down, yet remain seriously concerned about the issue. If costs are not the driver, what is? To uncover these more subtle issues, we asked qualitative questions to tease out respondents' fears and concerns.

Narcotics, addiction risk and the industry's deepening concern

For the third year we asked respondents to score their concern about opioids in work comp; results were identical for all three years. **Respondents judged opioids to be a very significant problem, giving it an average of 4.8. This remains the highest score for any question in the history of the survey,** a clear indicator of the level of the industry's anxiety over a problem it has yet to fully understand, much less address.

Payers have gotten the message – narcotics are highly problematic for workers comp claimants, employers, and insurers, and they are taking steps to address the problem. When asked what programs have been put in place to manage pharmacy, all but one had instituted "opioid alerts" to inform adjusters when certain levels of morphine equivalents had been exceeded, long-acting opioids had been dispensed, or treatment had extended beyond a certain time. In addition, all but two have programs designed to identify and address high-risk claimants; opioid use is a common predictor.

Responses to the final question of the survey are telling as well. When asked "What is the biggest single problem related to pharmacy benefit management in workers compensation?" the most common answer involved narcotics and opioids.

Physician dispensing

Physician dispensing accounted for over 35% of drug costs in 2012.

The concern over physician dispensing has grown over the last few years, driven by payers' own experiences and the research from NCCI and the Workers' Compensation Research Institute (WCRI) quantifying the dramatic increase in the percentage of drug dollars going to pay for physician-dispensed medications. The latest NCCI data indicates

physician dispensing accounted for 28% of drug costs in 2009, fully five points more than in the previous year.

Recent data pertaining to California, Illinois, Hawaii, Maryland, Florida, and other states indicate physician dispensing has continued to become more common.

There are several concerns with physician-dispensed drugs. Physician dispensing unnecessarily creates a health and safety risk for the injured worker receiving these prescriptions. Injured workers often see multiple physicians for their work-related injuries, in addition to their group health doctors, who may each prescribe multiple medications. Each of these independent doctors usually does not know the prescribing patterns of his/her peers or all of the other drugs the injured worker is taking. Nor do they usually know the patient's entire medical history.

In earlier surveys we asked respondents for their perspectives on physician dispensing/repackaging, and their almost universally negative responses made further surveying on this issue pointless. Instead, we asked respondents operating in states where dispensing exists to identify specific concerns regarding physician dispensing of repackaged drugs. When asked to indicate which of the following were concerns, respondents identified each of these as issues:

- Patient safety; physician-dispensed drugs do not go through the Drug Utilization Review (DUR) process. (all but one respondents)
- Potential duplicate therapy. (all but two)
- Higher cost due to repackaged drugs being priced higher than the same medications at retail stores. (all)
- Unnecessary medications or medications not related to claimant workers' comp injury. (all but one)
- Extended disability duration. (all but two)
- Higher overall medical cost. (all)

Clearly respondents are more sensitive to this issue than in the past, with concerns extending beyond the obvious cost issue into patient safety.

How respondents are controlling drug costs

In 2011, implementing new and upgrading existing clinical management programs was – by far – the most common change to respondents' pharmacy management programs. Although respondents had improved reporting, streamlined electronic processes, and addressed the removal of Walgreens' from their PBM's retail network (since added back), over half had also done extensive work to address opioid/narcotic prescribing, utilization and monitoring.

Notably, most of the responses to a similar set of questions in this year's survey involved upgrades/improvements to these clinical programs. All respondents save one had implemented significant changes to these programs in 2012. That respondent has been a

leader in addressing key issues so it may well be that individual's perception of "new" programs may be that anything "new" has to be ground-breaking.

Respondents are innovating at a rapid pace, pushing their PBMs and internal clinical departments to analyze, intervene and take action. Some programs are relatively "soft," involving letters to physicians and patient education. Others are decidedly not. Payers are hiring staff specifically to deal with doctors who are exhibiting potentially-problematic prescribing patterns. They are requiring physicians to "test for drug abuse" and comply with urine drug monitoring guidelines. There's a lot less faith that the treating physicians will do the right thing, and a lot more assertive actions to help make sure they do.

Drug testing

There has been more rapid adoption of urine drug testing/monitoring than of any other program/service in the 10 years we have been conducting this survey.

This was the second year we asked respondents if they were using a urine drug testing (UDT) program. In last year's survey, half of all respondents utilized a UDT program to monitor claimant compliance.

This year all but three of the 23 respondents either offer a program or will do so this year, and the three who don't have a "program" are advocating testing. Among those who did not answer in the affirmative, one "tried to direct to physicians who do that as part of their practice;" another "send[s] letters to treating docs and calls them to advise they need to perform urine drug testing; we rely on ACOEM and ODG guidelines," and the third "can't direct care, but we follow up with the docs to ensure THEY are doing it."

The biggest problem in work comp pharmacy management

We ask this question each year, and tracking responses over time has helped us identify trends and note the evolution of the industry over the last 10 years. While there are typically changes from year to year, there is usually some consistency as well. We'd be remiss if we didn't note that several respondents stated utilization, and the failure of payers to focus on the volume and type of drugs flowing through the system, remains the biggest issue.

With that said, for the third year the top vote-getter (with 8 responses) was the use of opioids and the increased use of narcotics.

Physician dispensing was a close second, with several respondents specifically citing the downstream impact on utilization review and clinical management efforts. Respondents also cited the societal issues that are driving workers' comp pharmacy issues, noting that it is very difficult to overcome issues that are much, much bigger than just work comp.

Conclusions

Pharmacy management in workers' comp has evolved dramatically over the 10 years we've been conducting the survey. From a focus on the price of the pill and the size of the retail pharmacy network in 2003 to today's concern about opioids, physician dispensing and clinical management, we've witnessed a remarkable increase in sophistication and understanding. With that said, it is evident that despite all the attention paid to and resources focused on this issue, payers' level of concern about pharmacy management continues to remain quite high.

That the dramatic increase in physician dispensing and payers' concern about implications for patient safety, disability duration and claims cost aren't the utmost concern to payers is evidence of the seriousness of the opioid issue. Payers are beginning to grasp just how difficult and complex this issue is: physician prescribing patterns; addiction and dependence; chronic pain management; and abuse, misuse and diversion are all closely related to the use of opioids.

With that said, it can be difficult to recall that drug costs are relatively flat.

With drug costs declining year over year, one could be forgiven for thinking payers believe they have drugs under control. Yet payers' evident level of concern, the active and ongoing efforts to improve results, the pressure on PBMs to deliver better penetration and lower costs, and payers' interest in new programs such as UDT are clear evidence that few believe pharmacy is "under control."

Finally, as the respondents cited above noted, we'd be remiss if we didn't acknowledge the significant impact of external factors on workers' compensation pharmacy, chief among them the nation's growing addiction to prescription pain medications. This is a societal issue, but one that is having a deep and damaging impact on comp, driving up costs, prolonging disability and killing claimants.

If the industry and individual companies within the insurance and reinsurance industry do not meet this challenge head-on, acknowledge it and develop effective programs to prevent, identify and treat abuse, misuse, addiction and dependency, we will almost certainly see the bankruptcy of several workers' comp insurers over the next decade.

It remains to be seen if insurers grasp the seriousness of this issue before it is too late.